Breast Prostheses Claim Form

To be completed by the eligible person

Please print clearly using capital letters.

Date of birth	Eligible person details	
Suburb City/town Postcode Suburb City/town Postcode Contact phone number	First name(s)	Last name
Unit/flat no. Street name Unit/flat no. Street name Suburb City/town Postcode Contact phone number Email address Caim details Claim details Initial claim Subsequent claim (Please tick relevant claim) Left Right Bilateral (Please tick relevant claim)		
Suburb City/town Postcode Suburb City/town Postcode Contact phone number	Date of birth	
Contact phone number Contact phone number Email address Claim details Claim details Left Right Bilateral (Please tick relevant claim)	Unit/flat no. Street no. Street name	
Contact phone number Contact phone number Email address Claim details Claim details Left Right Bilateral (Please tick relevant claim)		
Email address	Suburb City/town	n Postcode
Email address		
Claim details Initial claim Subsequent claim (Please tick relevant claim) Left Right Bilateral (Please tick relevant claim)	Contact phone number	
Claim details Initial claim Subsequent claim (Please tick relevant claim) Left Right Bilateral (Please tick relevant claim)		
Initial claim Subsequent claim (Please tick relevant claim) Left Right Bilateral (Please tick relevant claim)	Email address	
Initial claim Subsequent claim (Please tick relevant claim) Left Right Bilateral (Please tick relevant claim)		
Left Right Bilateral (Please tick relevant claim)	Claim details	
	Initial claim Subsequent claim (Pleas	se tick relevant claim)
Date of purchase	Left Right Bilateral (Please	tick relevant claim)
	Date of purchase	
Item(s) purchased	Item(s) purchased	
Total amount of purchase \$ Note:		
Total amount claimed A medical certificate (if initial claim) and proof of purchase must accompany this form.		ate (if initial claim) and proof of purchase must accompany this form.
Certification (Please tick the appropriate box)	Certification (Please tick the appropriate box)	
I am submitting this claim on my own behalf. My Ministry of Health payee number is:	I am submitting this claim on my own benati. My Ministr	y of Health payee number is:
I am authorising my provider to claim for this service on my behalf.	I am authorising my provider to claim for this service on	my behalf.
I declare that, as an eligible person, I am entitled to publicly funded health care in accordance with any eligibility direction		, _ ,
issued under section 32 of the New Zealand Public Health and Disability Act 2000, or any eligibility direction continued by section 112 (1) of that Act, and declare that I am not eligible for any kind of assistance from the Accident Compensation		
Corporation. I certify that as the eligible person named above, I have been supplied with the breast prosthesis services claimed.		
Signature Date	Signature	Date

For Ministry of Health us	se only		Date
Total amount payable	\$	Checked by	

Once completed, please sign and send printed form to: Ministry of Health, Private Bag 1942, Dunedin 9054 For further enquiries, telephone: 0800 458 448

